AMHERST HEALTH DEPARTMENT

70 BOLTWOOD WALK • AMHERST • MA • 01002
MAIN Office (413) 259-3077 Fax (413) 259-2404
www.amherstma.gov

RENEWAL FOOD ESTABLISHMENT APPLICATION

Name of Establishment _____ Date _____

Business Address _____ Business Phone _____

Mailing Address (if different) _____

Owner _____ Owner's Phone _____

Address of Owner _____

Name & Title of Applicant (if different from Owner) _____

If Corporation or partnership, give name, title & home address of each officer or partner. Attach additional paper if needed.

Name	Title	Home Address	Home Phone

State of Incorporation _____ Name & Address of Local Agent _____

Emergency Response Person: Name _____ Home phone _____

Type of Establishment	Fee	Duration of Permit	Amount to be Paid
Bakery	150.00	☐ Annual	_____
Catering	150.00		_____
Food Establishment	300.00	☐ Temporary	_____
Fraternities/Sororities	100.00		_____
Frozen Dessert	100.00		_____
Mobil Food*	125.00		_____
Residential Kitchen	75.00		_____
Retail	200.00		_____
Supermarket	900.00		_____
Organizations/Churches	100.00		_____
		Total	_____

Please Note The Following Late Fees Will Be Enforced

First 30 Days Overdue $50.00..... 60 Days & Each Month Thereafter $100.00

No Charge for Initial Inspection & First Re-inspection $75.00 Each Inspection Thereafter.

See over for additional information and signatures→

ADDITIONAL INFORMATION

Water Source ☐ Town ☐ Well Sewage Disposal ☐ Town ☐ Private Grease Trap ☐ Yes ☐ No

Days & Hours of Operation _____ Number of Seats _____

Food Being Served: _____

Persons Trained as Certified Food Protection Managers ☐ Yes ☐ No How Many? _____
Please list:

Name _____ Name _____ Name _____

Name _____ Name _____ Name _____

IN ORDER TO RECEIVE YOUR 2014 FOOD LICENSE:
Copies of the Certified Food Protection Manager Certification Must Be Included With Your Application

Persons Trained in Food Allergen Awareness Act ☐ Yes ☐ No How Many? _____
Please list:

Name _____ Name _____ Name _____

Name _____ Name _____ Name _____

Must Submit Copies of Food Allergy Awareness Video Training Certification for Each Individual

Persons Trained in Anti-Choking Procedures (if 25 seats or more) ☐ Yes ☐ No How Many? _____
Please list:

Name _____ Name _____ Name _____

Name _____ Name _____ Name _____

Must Submit Copies of Anti-Choking Certifications for Each Individual

***MOBILE FOOD UNITS OR PUSHCARTS**

☐ COPY OF PEDDLAR'S LICENSE ☐ LIST OF HAND WASHING AND TOILET FACILITIES

Submitted Applications to: ☐ Board of Selectman ☐ Fire ☐ Police

TEMPORARY PERMIT

Start Date: _____ End Date: _____

_____

√ Signature of Applicant

Pursuant to M.G.L. CH. 62C Sec. 49A, I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all State Taxes required under law.

_____

√ Signature of Individual or Corporate Name

By _____

Corporate Officer (if applicable) **Social Security Number or Federal Identification Number**

Workers' Compensation Insurance Affidavit (M.G.L. c. 152 #25C (6))

I, _____ do hereby certify that:

1. [ ] I am an employer providing the following workers compensation coverage for my employees:
_____ (Policy # / Insurance Company)

2. [ ] I am not required to have workers' compensation insurance under M.G. L. c. 152, Sect. 25 (c) (6)

***Any applicant who checks #1 above must also complete and submit the Worker's Compensation Affidavit.**

PAYMENT IS DUE WITH COMPLETED APPLICATION

Return to: Amherst Health Department
Attn: License Application
Bangs Community Center
70 Boltwood Walk
Amherst, MA 01002

Make Check Payable to: Town of Amherst

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name: _____

Insurer's Address: _____

City/State/Zip: _____

Policy # or Self-ins. Lic. #_____ Expiration Date: _____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature: _____ Date: _____

Phone #: _____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ **Permit/License #** _____

Issuing Authority (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person: _____ **Phone #:** _____

Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an ***employee*** is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An ***employer*** is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that "**every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required.**" Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111

Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE
Fax # 617-727-7749
www.mass.gov/dia

Form Revised 5-26-05